PARK CITY IMAGING

1850 SIDEWINDER DRIVE, SUITE 410
PARK CITY, UT 84060
PHONE: 435-615-0250
FAX: 435-615-0252

Date: _____

RELEASE OF RECORDS

Patient Name: _____ Birthdate: _____
Please Print

The enclosed film(s) is part of your permanent record. The center is legally responsible for maintaining custody of the film(s) at all times. We therefore require your signature to indicate that you are permanently removing the film(s) from the center and acknowledge receipt into your custody.

A copy of the interpretation report may also be included and is hereby included in this release. You are further acknowledging and agreeing to release Park City Imaging from any and all claims, suits, damage, or any actions whatsoever, which arises from your removal of the records from the center.

I further understand that the disclosure of this information carries with it the potential for unauthorized re-disclosure and the information may no longer be protected by federal confidentiality rules.

Patient Signature: _____

Date: _____

Are Films Being Taken to Another Facility or Doctor? Yes No

Name of Doctor/Facility: _____

Type of Study: _____

Photo ID Verified? Yes No Employee's Initials _____